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MONTANA RESPONDS TO HIV/STD

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Published quarterly by the HIV/STD Program of the Montana Department of Health and Environmental Sciences

Volume 1, Issue 1 Spring 1994

STATE WIDE HIV/AIDS CONFERENCE SCHEDULED FOR MAY IN HELENA

Two years have passed since the third statewide HIV/AIDS conference in Montana. In Helena, May 18-20, health care providers, educators, public health officials, mental health practitioners, employers, drug and alcohol counselors, and persons affected by HIV will have the opportunity once again to update their skills in prevention and treatment, receive current information on the epidemic and network with persons working towards a common goal - the eradication of HIV in Montana.

HIV IV '94 Time To Act! will open Wednesday, May 18, at 3:00 pm with a keynote address on national AIDS policy and the impact of health care reform on prevention and treatment by **Kristine Gebbie**, National AIDS Policy Coordinator for President Clinton. **Dorothy Bradley**, Chair, Montana Health Care Authority, will follow with Montana's response to HIV and a health care reform progress report.

From this ambitious beginning, two days of excellent and varied offerings will follow. **Thursday** will lead off with an overview of HIV and its prevention in the Native American communities across Montana. The rest of the day will primarily focus on mental health and medical care and treatment for persons with HIV. Standards of care, current treatment updates, alternative medicine, burnout in caregivers, and the challenge of living with HIV will all be addressed throughout the day, with such experts as **Martin Delaney**, founder and Executive Director of Project Inform, and **Dr. David Spach**, Infectious Disease Specialist, University of Washington AIDS Education and Training Center.

Friday will be a potpourri of community based strategies. Montana is diverse and all facets of Montana, our community-at-large, must respond in its own unique way to HIV infection. A wide range of topics will be offered in both workshop and presentation format: the role of schools, businesses, churches and families in HIV prevention; marketing techniques to enhance prevention strategies; self-esteem and sexual behavior change for gay and bisexual men. In addition, there will be a chance for all of us to hear the experiences of Montanans, men and women within our borders, living with HIV/AIDS, and for these same persons to share these experiences with each other.

We hope that many of you will be able to attend **HIV IV '94, Time To Act!** Together we can transform anger, fear and indifference into action! The deadline to register is May 2; the fee is $75.00, which includes one reception and two luncheons. There are fee waivers for persons with HIV/AIDS. Call the Center for Continuing Education at the University of Montana, (406) 243-2094 for brochure and registration.

AIDS MASTERY WORKSHOP EXPLORE The POSSIBILITIES

On May 20-22, the weekend following the completion of **HIV IV '94 Time To Act**, the **AIDS Mastery Workshop** will be offered at the Feathered Pipe Ranch in Helena. These dates were chosen to accommodate potential participants who will already be in Helena attending the HIV/AIDS conference.

The AIDS Mastery Workshop is based on the belief that the quality of life does not have to be determined by its circumstances or durations. The purpose of the workshop is to empower people infected or affected by HIV/AIDS to live fully and powerfully in each moment. Facilitated by highly trained leaders with HIV life professionals safe forum in which to deal with and explore the physical experience. The AIDS Mastery includes one-on-one interaction between facilitator and participants, group discussions, personal exploration, emotional exercises, and guided visualizations.

During the AIDS Mastery weekend the participants receive the highest level of care and attention. To this end, the Feathered Pipe is the perfect location for the workshop - a peaceful place to feel nurtured and supported.

The Feathered Pipe Ranch is a beautiful lakeside retreat center. The proprietors have very generously offered their facility, including lodging and all meals at the lowest possible cost. Their food is gourmet, and most is fresh and organic. There is also a sauna and a hot tub available to all guests.

Since 1986, the AIDS Mastery has been offered in thirty cities. It gives people with HIV/AIDS, their families, friends, and health care professionals safe forum in which to deal with and explore the physical, emotional, and spiritual issues that confront the lives of anyone facing AIDS.

The AIDS Mastery is fiscally self-sustaining through in-kind contributions, scholarship grants, and participant donations. No one is turned away for lack of funds.

For questions, registration or to make a donation to help someone attend this workshop, call Cindy Ballew, AIDS Mastery Leader at (406) 585-8038.

Montana Department of Health and Environmental Science

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HIV/STD Program

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STD Program Officer:
STD Field Health Officer: Terry Peterson
STD Administrative Assistant:
HIV Surveillance Officer: Jim Murphy
Public Health Educator: Claudia Montagne
Public Health Educator: Judy Peterson
Administrative Assistant: Valinda Holmes
Administrative Aide: Kim Hauge

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

The Northwest Portland Indian Health Board was granted a five year HIV/STD Prevention Project from the CDC. They have sub-contracted with the Chippewa Cree Tribe to serve the Billings Area Tribes and have hired Lisa Whitford, a native of Rocky Boy as their Montana/Wyoming Regional Training Specialist.

Lisa has a B.S. degree in Health Care Administration and is also a certified American Red Cross HIV/AIDS instructor. She is available to offer training and education on HIV/STD-AIDS to any organization or department in her contracted region that feels they need this service.

Lisa will be contacting each Tribal Health Department on the reservations in Montana and Wyoming to schedule informal site visits and set up training sessions. She will also be assisting the Tribal Councils in preparing an AIDS Policy for their tribe and forming an AIDS Task Force on each reservation.

Lisa is located at Rocky Boy Health Board, Chemical Dependency Center. Her office hours are Monday - Friday 8:00 am to 4:30 pm. If anyone has any questions about the Project or would like to assist Lisa with anything, please feel free to contact her at (406) 395-4037 or 395-4064.

NAMES Project Comes to Montana

About 550 national panels along with several quilt panels commemorating Montanans who have lost their lives to AIDS will be on display at the Whitefish High School gymnasium, Whitefish, Montana. Opening ceremonies will be April 22 at 8 pm with a dedication of those Montana panels. Display will continue through April 23 - 24. For more information about the quilt project call (406) 758-5756.

HIV/STD in Montana
Acquired Immunodeficiency Syndrome (AIDS)
Cumulative Surveillance Report - As of March 31, 1994

1. Exposure Category	Adult/Adolescent Males	(%)	Females	(%)	Total	(%)
Men Who Have Sex With Men	125	(66)	0	(0)	125	(60)
Injecting Drug Use	23	(12)	2	(11)	25	(12)
Men Who Have Sex with Men and Injecting Drug Use	24	(13)	0	(0)	24	(11)
Hemophiliac	7	(4)	0	(0)	7	(3)
Heterosexual Contact	3	(2)	11	(58)	14	(7)
Transfusion w/ Blood/Products	3	(2)	4	(21)	4	(3)
None of the Above/Other	6	(3)	2	(11)	7	(3)
Total Adults/Adolescent	190	(100)	19	(100)	209	(100)
	Pediatric					
	Males	(%)	Females	(%)	Total	(%)
Parent at risk/has AIDS/HIV	2	(100)	1	(100)	3	(100)
Total Pediatric	2	(100)	1	(100)	3	(100)

2. Age	Cases	(%)
Under 5	3	(1)
5-12	0	(0)
13-19	2	(1)
20-29	49	(23)
30-39	98	(46)
40-49	40	(19)
Over 49	20	(9)
Unknown	0	(0)
Total	212	(100)

3. Race/Ethnicity	Cases	(%)
White, Not Hispanic	186	(88)
Black, Not Hispanic	5	(2)
Hispanic	8	(4)
Asian/Pacific Is.	0	(0)
Am. Indian/Alaskan	13	(6)
Unknown	0	(0)
Total	212	(100)

As of March 31, 1994 there have been 442 cumulative positive HIV tests from 58,428 tests conducted through the MDHES Public Health Laboratory since 1985. Due to anonymous HIV testing, the cumulative number of HIV positive tests may contain duplicates.

Nationally, as of December 31, 1993 361,509 cases of AIDS and 220,871 deaths have been reported to the Centers for Disease Control.

*Includes 148 Montana AIDS cases and 64 cases reported to Centers for Disease Control diagnosed in other states who moved to Montana.

STD MORBIDITY REPORT
Report Period: 1/1/94 - 3/31/94

Disease	Male	Female	Total
Chlamydia			
Private	11	88	99
Public	29	131	160
Military	9	2	11
IHS	8	32	40
Subtotal	57	253	310
Chlamydia with PID			
Private	0	5	5
Public	0	4	4
Subtotal	0	9	9
Uncomplicated Gonorrhea			
Private	5	3	8
Public	3	6	9
Military	4	0	1
IHS	3	6	9
Subtotal	12	15	27
Gonorrhea with PID			
Private	0	2	2
Subtotal	0	2	2

STD/HIV: LINKS

In the March 1994 "Positively Aware" newsletter, in the "In Focus: Clinical Care" section of the newsletter, there is an article titled "Sexually Transmitted Diseases and HIV Infection" by Ross Slotten of St. Joseph Hospital in Chicago. Dr. Slotten has practiced medicine for 10 years and has had extensive experience treating people with HIV and STDs.

He states: "The emergence of the AIDS epidemic over the last decade has overshadowed a parallel epidemic of sexually transmitted diseases (STDs) such as gonorrhea."

"As with AIDS, there is no evidence that STDs are abating. In fact, studies have shown that STDs may be on the rise again after a slowdown in the late 1980s. Because many of the same risk factors for HIV apply to STDs, epidemiologist-scientists who track diseases fear that the rise in STDs may herald a concurrent rise in HIV transmission."

"Many studies have shown that people with an STD are more susceptible to HIV infection. An STD may cause lesions on the penis, rectum, or vagina, giving HIV an access point to the blood stream. Another reason is that infected sex organs are flooded with CD4 cells -- the cells that are the primary targets of HIV."

"This means that HIV transmission may be both behavioral and mechanical. Treating the sex partner(s) to reduce reinfection, and the risk reduction messages that are provided the patient in the interview process (i.e., abstinence, monogamy, limiting the number of partners, and the proper use of condoms) grows increasingly important as we increase our knowledge of HIV transmission. Remember, always ask, 'Who else'."

Dr, Slotten concludes "The most common STDs, gonorrhea and chlamydia, are not made more severe by HIV infection; therefore, the CDC recommended therapies for both diseases would be sufficient. Herpes can be very severe and may not have a classic appearance in people with HIV. Fortunately, most people respond to 7-10 days of acyclovir, with the oral form preferred to topical cream."

"The treatment of primary and secondary syphilis in the HIV-positive person is usually the same as in the uninfected individual -benzathine penicillin for one day. Alternative antibiotic therapies for the HIV-positive person are not recommended. If the person is allergic to penicillin, then desensitization should be undertaken."

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Volume 1, Issue 2 Summer 1994

HIV PREVENTION COMMUNITY PLANNING PROCESS

The Montana Department of Health and Environmental Sciences (MDHES) is expanding its collaboration with communities statewide in developing priorities for use of the federal prevention funds it receives. The goal of the planning process is to set priorities for the state's HIV/AIDS prevention programs and resources on the basis of a comprehensive needs assessment and planning effort carried out at the community level. This process will build on the assessments and prevention recommendations contained in the recent Report to the Governor: Montana Responds to HIV/AIDS.

The U.S. Centers for Disease Control and Prevention is providing support to Montana ($94,000) and other states to conduct community planning efforts. All state and territorial health departments that receive federal funding for HIV prevention are required to implement community-based HIV prevention planning. Beginning with 1995, applications to support HIV prevention activities such as HIV counseling, testing, referral and partner notification, health education, risk reduction, community-level intervention, outreach and public information campaigns must be based on findings and recommendations of this planning process.

The planning process is to:

* nominate, recruit and select members for the planning groups;
* determine the present and future extent, distribution and impact of the epidemic in selected populations in the state;
* conduct a HIV prevention needs assessment;
* define potential impact of specific strategies and interventions to prevent HIV in defined populations;
* set program priorities for specific HIV prevention strategies;
* evaluate effectiveness of the planning process.

The MDHES formed and convened an ad hoc committee in February, 1994 to provide guidance and discussion on HIV prevention planning structure and process for the application. The ad hoc committee was comprised of representatives from each of the five Governor's health planning districts, including local health departments, community-based service organizations, and one representative of the Native American community.

Regional planning groups will be formed in each of the Governor's Health Planning Districts. Bob Robinson, Director of MDHES, has named the following health department representatives as co-chairs of the regional planning groups in their areas:

Cherry Loney, City-County Health Officer in Great Falls;

Jeanne Seifert, Administrator of the Dawson County Health Department in Glendive;

Dennis Klukan, Flathead City-County Health Officer in Kalispell;

Ron Seibel, AIDS Services Coordinator in Billings;

and Dan Dennehy, Butte-Silver Bow Health Officer in Butte.

Each of these local health department co-chairs will be soliciting and choosing members for the planning group within their region, who will be composed of persons who reflect the characteristics of the HIV epidemic in their area; scientific experts; service providers and other organization representatives. Once the regional planning group convenes, they will choose another co-chair from within their group.

Those persons interested in serving on their regional planning groups may contact the person within their region or contact Bruce Desonia, AIDS Program Manager, MDHES, at 444-3565 for more information.

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Syphilis Outbreak

Five cases of early syphilis have been reported in the Billings area since April of 1994, with all the cases related to the same outbreak. All five cases have occurred in Native Americans. Two of the cases were identified by physicians, after the cases presented with acute genital herpes infections. Three of the cases were identified through contact tracing.

An unrelated case was reported from the Butte area. This brings the total to 6 cases in the second quarter of 1994 as compared to 4 for all of 1993. Three of the four cases in 1993 were also from the Billings area.

The STD Program of MDHES is recommending that health care providers serving clients in the Billings area consider screening for syphilis through the summer, as other cases are anticipated.

Reports of syphilis should be immediately reported to your local health officer. Terry Peterson, Field Health Officer in the STD Program, can be reached at 444-3949.

STD Program Positions

The Program Officer position that supervises the STD Program has been offered to Helen McCaffrey of Ann Arbor, Michigan. Ms. McCaffrey received her M.P.H. from the University of Michigan and has spent some time in Montana, including a position as a research analyst with the Billings area office of the Indian Health Service. She starts in her new job on July 11.

Another new addition to the HIV/STD Program Staff is Jamey Hawe, filling the Administrative Aide position in the STD Program.

Montana Department of Health and Environmental Science

Director: Bob Robinson

HIV/STD Program

HIV/STD Program Manager: Bruce Desonia
STD Program Officer: Helen McCaffrey
STD Field Health Officer: Terry Peterson
STD Administrative Assistant: Jamey Hawe
HIV Surveillance Officer: Jim Murphy
Public Health Educator: Claudia Montagne
Public Health Educator: Judy Peterson
Administrative Assistant: Vacant
Administrative Aide: Vacant

Jamey is from Helena, where she completed two years at Carroll College in Health Information Management. She is currently studying data processing at the Helena Vocational Technical Center.

Approaches to Dealing with Individuals Who Knowingly Expose Others to Sexually Transmitted Diseases

Although reports of individuals knowingly exposing others to sexually transmitted diseases (STDs) are rare, isolated instances have been reported to local health departments (as per state law 50-16-108, MCA) throughout Montana. In order to assist state and county health personnel in their response to such reports, MDHES has finalized a guidance document outlining suggested steps that may be taken to address problems as they occur. While the decision-making guidance focuses on HIV transmission, the procedures can be easily adapted to other STDs.

The document, entitled Decision-Making Guidance for Recalcitrant HIV Clients, encourages public health officials to follow a systematic and progressive approach to such reports. The suggested approach begins with a thorough investigation and assessment of the complaint. After the investigation several options are discussed that may be exercised depending upon the situation. Such options include counseling, assessing the ability of the suspected individual to understand the modes of disease transmission, further monitoring, and/or detaining the suspect in the most severe cases.

The guidance document will be disseminated to all local health departments and by the Virtual Medical Center (VMC) Bulletin Board System. Copies may also be obtained by calling or writing the Montana AIDS Program at 444-3565, P.O. Box 200901, Helena, MT 59620-200901.

HIV/STD in Montana
Acquired Immunodeficiency Syndrome (AIDS)
Cumulative Surveillance Report - As of June 30, 1994

1. Exposure Category	Adult/Adolescent Males	(%)	Females	(%)	Total	(%)
Men Who Have Sex With Men	128	(65)	0	(0)	128	(59)
Injecting Drug Use	23	(12)	2	(10)	25	(12)
Men Who Have Sex with Men and Injecting Drug Use	26	(13)	0	(0)	26	(12)
Hemophiliac	7	(4)	0	(0)	7	(3)
Heterosexual Contact	3	(2)	12	(60)	15	(7)
Transfusion w/ Blood/Products	3	(2)	4	(20)	4	(3)
None of the Above/Other	6	(3)	2	(10)	8	(4)
Total Adults/Adolescent	196	(100)	20	(100)	216	(100)
	Pediatric					
	Males	(%)	Females	(%)	Total	(%)
Parent at risk/has AIDS/HIV	2	(100)	1	(100)	3	(100)
Total Pediatric	2	(100)	1	(100)	3	(100)

2. Age	Cases	(%)
Under 5	3	(1)
5-12	0	(0)
13-19	2	(1)
20-29	52	(24)
30-39	100	(46)
40-49	40	(18)
Over 49	22	(10)
Unknown	0	(0)
Total	217	(100)

3. Race/Ethnicity	Cases	(%)
White, Not Hispanic	190	(88)
Black, Not Hispanic	5	(2)
Hispanic	8	(4)
Asian/Pacific Is.	0	(0)
Am. Indian/Alaskan	13	(6)
Unknown	0	(0)
Total	214	(100)

As of June 30, 1994, there have been 453 cumulative positive HIV tests from 61,427 tests conducted through the MDHES Public Health Laboratory since 1985. Due to anonymous HIV testing, the cumulative number of HIV positive tests may contain duplicates.

Nationally, as of December 31, 1993, 361,509 cases of AIDS and 220,871 deaths have been reported to the Centers for Disease Control.

*Includes 153 Montana AIDS cases and 66 cases reported to Centers for Disease Control diagnosed in other states who moved to Montana.

STD MORBIDITY REPORT
Report Period: 4/1/94 - 6/30/94

Disease	Male	Female	Total
Chlamydia			
Private	21	87	108
Public	29	156	185
Military	13	6	19
IHS	11	66	77
Subtotal	74	315	389
Chlamydia with PID			
Public	0	2	2
Uncomplicated Gonorrhea			
Private	2	2	4
Public	2	4	6
IHS	2	3	5
Subtotal	6	9	15
Syphilis-Sec			
Private	0	2	2
Syphilis-El			
Private	1	0	1
Public	1	1	2
IHS	1	0	1
Total	3	1	4

To report cases of patients who meet the CDC definition of AIDS, please contact Jim Murphy, Surveillance Officer, at HIV/STD Program, (406)444-4744.

Zidovudine (AZT) for the Prevention of HIV Transmission from Mother to Infant

On February 21, 1994, the National Institutes of Health's National Institute of Allergy and Infectious Disease (NIAID) and National Institute of Child Health and Human Development (NICHD) announced preliminary results from a randomized, multicenter, double-blinded clinical trial of zidovudine (AZT) to prevent HIV transmission from mothers to their infants (AIDS Clinical Trials Group [ACTG] protocol 076).

Based on these preliminary results, the Public Health service makes the following interim recommendations:

all health care workers providing care to pregnant women and women of childbearing age should be informed of the results of the ACTG protocol 076;

HIV-infected pregnant women meeting the protocol eligibility criteria should be informed of the potential benefits by unknown long-term risks of AZT therapy as administered in ACTG protocol 076, and decisions to use AZT for prevention of perinatal transmission should be made in consultation with their health care providers;

health care providers should inform their patients that this AZT regimen substantially reduced, but did not eliminate, the risk for HIV infection among the infants;

and, until the potential risk for teratogenicity and other complications from AZT therapy given in the first trimester can be assessed, AZT therapy only for the purpose of reducing the risk for perinatal transmission should not be instituted earlier then the 14th week of gestation.

These recommendations appeared in the April 29, 1994 Morbidity and Mortality Weekly Report (MMWR) (Vol.43/No.16). Single copies of this report will be available free until April 29, 1995, from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231.

A Public Health Service Task Force has been appointed to continue discussions about further, potential implications of the ACTG protocol 076 trials on public health programs. This group may issue additional recommendations in the upcoming months.

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MONTANA RESPONDS TO AIDS

Published quarterly by the HIV/STD Program of the Montana Department of Health and Environmental Sciences

Volume 1, Issue 3 Fall 1994

HIV/AIDS and Health Care Reform

The HIV/AIDS epidemic poses a unique challenge to the scientific and medical systems, defying the best efforts of researchers and care providers to find a vaccine, a cure, or even effective treatments. AIDS has also intensified and shed light and heat on another system - America's troubled health care system. The shabby state of our health care safety net is apparent to anyone who is uninsured or underinsured, chronically ill or disabled, poor, incarcerated, homeless, undocumented, or otherwise without guaranteed access to comprehensive, affordable health care.

The National Commission on AIDS in its 1991 report, ***America Living With AIDS,*** outlined the bleak intersection between HIV/AIDS and our crumbling health care system...***most of the ills our present health care system suffers stem form old wounds that have been poorly patched and bandaged or ignored entirely. The HIV/AIDS epidemic did not leave 37 million or more Americans without ways to finance their medical care-but it did dramatize their plight.***

High quality basic and HIV/AIDS-specific health care is a life and death issue for people living with HIV/AIDS. A look at how such care is currently paid for reveals the importance of comprehensive national health care reform to the health and well-being of people living with HIV/AIDS.

Currently, according to Health Care Financing Administration data, 45 percent of Americans living with AIDS are Medicaid recipients, 4 percent have their care paid for by Medicare, and another 27 percent are entirely uninsured. Fewer than one fourth have private health insurance.

A look at each option shows serious inadequacies. Medicaid has poor and variable benefits. Medicaid reimbursement is so low that many physicians across the country will not accept Medicaid patients. Couple this with the fact that people living with HIV/AIDS often require the expertise of a variety of specialists and the end result is poor access to providers.

The Medicare system, although it only pays for 4 percent of AIDS patients, also has serious inadequacies. Medicare currently has no prescription drug coverage, no long-term care, and no limits on the total amount of medical expenses people can be required to pay for each year out of their own pockets.

Both Medicaid and Medicare fail to adequately cover an essential service for many people living with HIV/AIDS-home health care.

People who are uninsured get only sporadic care, typically through emergency rooms.

Regardless of coverage or lack of it, there's another hidden injustice for people with HIV/AIDS. A recent CDC survey of primary care physicians nationwide revealed many are unwilling to provide care to people who are HIV-positive.

Even the minority of Americans with AIDS who are privately insured can face a host of barriers to care: pre-existing condition exclusions and caps on overall care for AIDS treatment; prohibitive costs for life-saving drugs; discrimination based on sexual orientation and presumed risk; and a range of other common practices that can make health care a frustrating, financially debilitating, and sometimes life-threatening condition. And, as is true for people with chronic illnesses or disabilities, many people with HIV/AIDS

lose even this fragile access to care when they become too sick to work and eventually, lose their private health insurance.

One source of funding for people living with HIV/AIDS is the Ryan White CARE Act. Developed as an initial care response to emergency needs in communities caring for large numbers of people with HIV/AIDS, the Ryan White program was designed to help create a continuum of out-of-hospital supportive services by filling the gaps in HIV/AIDS care.

The Ryan White CARE Act has never been fully funded, but even if it had been, it would not have provided enough money to keep up with the explosion of the HIV/AIDS epidemic and the accompanying need for care. It must be remembered that the Ryan White CARE Act was intended as an emergency relief program to strengthen our crumbling health care safety net. It cannot, and was never intended to, take the place of comprehensive national health care reform.

Health Care security is an immediate, desperate need for any person living with HIV/AIDS. It is a pressing need for any American when an accident, disabling condition, or catastrophic illness strikes. Only comprehensive national health care reform that is designed to meet the needs of our most vulnerable citizens will provide true health care security for all.

Division of STD/HIV Grantee Meeting, Washington, D.C.

During August 1994, the Division of STD/HIV Prevention Grantee Meeting was held in Washington, D.C. The grantees represent a widely diverse group of state and city health departments, community-based organizations, and national and regional minority organizations. Bruce Desonia, AIDS Program Manager for the Montana Department of Health and Environmental Sciences (MDHES), and Helen McCaffrey, the STD Program Officer for MDHES, attended this five day conference designed to provide a forum for innovative and successful strategies, information, and problem-solving in STD and HIV prevention.

Included in the presentation of strategies for HIV/STD prevention was the Transtheoretical Model of behavior change. The major premise of the Transtheoretical Model is that behaviors like condom use are adopted in increments, and cannot be intervened upon, or measured by, an "all or nothing" standard. These increments, called Stages of Change, reflect a different level of readiness to change high risk behavior to maintain risk reduction practices such as condom use: **Pre-contemplation** at which there is not intention to change behavior; **Contemplation** in which people are aware that a problem exits but have not yet made a change; **Ready for Action** in which people are intending to take action; **Action** in which people modify their behavior, experiences or environment; and **Maintenance** in which people work to prevent relapse. By tailoring risk reduction messages and activities, programs may be more likely to influence movement by women through the Sates of Change, and ultimately toward the desired long-term outcome of consistence condom use.

World AIDS Day 1994

In 1994, The International Year of the Family, The World Health Organization (WHO) is marking World AIDS Day (WAD) under the banner ***AIDS and the Family***. Traditional and non-traditional families have a crucial role to play in addressing the HIV/AIDS epidemic.

WHO urges the world to focus on how families of all kinds are affected by AIDS, on how they can be more effective in prevention and care, and on how they can contribute to global efforts against the disease.

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Men Who Have Sex With Men	133	(65)	0	(0)	133	(59)
Injecting Drug Use	25	(12)	2	(9)	27	(12)
Men Who Have Sex with Men and Injecting Drug Use	26	(13)	0	(0)	26	(12)
Hemophiliac	7	(4)	0	(0)	7	(3)
Heterosexual Contact	5	(2)	13	(59)	18	(8)
Transfusion w/ Blood/Products	3	(1)	4	(18)	7	(3)
None of the Above/Other	5	(2)	3	(14)	8	(4)
Total Adults/Adolescent	**204**	**(100)**	**22**	**(100)**	**216**	**(100)**
	Pediatric					
	Males	(%)	Females	(%)	Total	(%)
Parent at risk/has AIDS/HIV	2	(100)	1	(100)	3	100)
Total Pediatric	**2**	**(100)**	**1**	**(100)**	**3**	**(100)**

2. Age	Cases	(%)	3. Race/Ethnicity	Cases	(%)
Under 5	3	(1)	White, Not Hispanic	200	(88)
5-12	0	(0)	Black, Not Hispanic	5	(2)
13-19	2	(1)	Hispanic	8	(4)
20-29	55	(24)	Asian/Pacific Is.	0	(0)
30-39	104	(45)	Am. Indian/Alaskan	16	(6)
40-49	42	(18)	Unknown	0	(0)
Over 49	22	(10)			
Unknown	1	(0)	**Total**	**229**	**(100)**
Total	**229**	**(100)**			

As of June 30, 1994, there have been 453 cumulative positive HIV tests from 61,427 tests conducted through the MDHES Public Health Laboratory since 1985. Due to anonymous HIV testing, the cumulative number of HIV positive tests may contain duplicates.

Nationally, as of December 31, 1993, 361,509 cases of AIDS and 220,871 deaths have been reported to the Centers for Disease Control.

*Includes 153 Montana AIDS cases and 66 cases reported to Centers for Disease Control diagnosed in other states who moved to Montana.

STD MORBIDITY REPORT

Disease	Male 1/93-9/93	Male 1/94-9/94	Female 1/93-9/93	Female 1/94-9/94	Total 1/93-9/93	Total 1/94-9/94
Chlamydia						
Private	50	44	272	267	322	311
Public	99	79	529	387	628	466
Military	24	27	17	12	41	39
IHS	22	27	171	116	193	143
Subtotal	**195**	**177**	**989**	**782**	**1184**	**959**
Chlamydia with PID						
Public	0	0	8	10	8	10
Private	0	0	3	8	3	8
Uncomplicated Gonorrhea						
Private	10	13	11	8	21	21
Public/Military	8	15	8	16	16	31
IHS	6	6	14	12	20	18
Subtotal	**24**	**34**	**33**	**36**	**57**	**70**
Syphilis-Pri/Sec						
Private	0	0	1	3	1	3
Syphilis-El						
Private	1	1	0	0	1	1
Public	1	2	0	1	1	3
IHS	1	1	0	0	1	1
Total	3	4	0	1	3	5

To report cases of patients who meet the CDC definition of AIDS, please contact Bruce Desonia, Program Manager, at HIV/STD Program, (406)444-2457.

STD Clinic Site Visits-1994

The Montana Department of Health and Environmental Sciences Sexually Transmitted Disease (STD) Program recently completed site visits to all 21 designated STD clinics. These 21 clinics are strategically located throughout Montana (a reminder of how geographically vast our state is!). Helen McCaffrey, Program Officer of the STD Program, made visits in the western half of the state, while Terry Peterson, Field Health Officer, covered the eastern portion of the state.

Clinics were supplied with a video on specimen collection for Chlamydia trachomatis, 1000 condoms apiece, and an example of the assorted pamphlets offered through the STD Program. The Montana Sexually Transmitted Disease Program wishes to extend our thanks to each of the hard working people that staff these clinics. It's always a pleasure to work with such dedicated professionals! We look forward to working with you throughout this year and the years to come.

Governor Racicot Names AIDS Advisory Council

In August Governor Racicot signed an executive order establishing the AIDS Advisory Council which met for the first time on September 26 at the Capitol Building. The governor's order noted that, "...the need for an advisory and leadership mechanism critical for an effective and publicly supported response to a very serious public health issue." The council will respond to the recommendations for action outlined in the document entitled "A Report to the Governor: Montana Responds to HIV/AIDS". In addition, the council is to provide the leadership required to recommend public policy that assures the initiation, coordination, promotion, implementation, and evaluation of services and activities that can effectively arrest the spread of the HIV infection and provide humane treatment for those that are infected.

Members of the AIDS Advisory Council includes: Verbena Savior, Poplar; Pam Carter, Bozeman; Elizabeth Olberding, Helena; David Rice, Havre; JoAnn Flaa, Glasgow; Connie O'Conner, Helena; David Herrera, Billings; Paul Goodman, Billings; Rita Munzenrider, Kalispell; Steve Bennetts, Gt. Falls; Louise Sullivan, Townsend; D. Gregory Smith, Helena; and Terri Dunn, Whitefish. Names have been submitted to Governor Racicot to allow a teen representative and a person with HIV/AIDS participate as council members. The council has scheduled its second meeting for November 7, 1994 in Helena (site to be announced). All interested members of the public are invited to attend.

Montana Responds to HIV/STD is a quarterly publication of the HIV/STD Program of the Department of Health and Environmental Sciences. Its purpose is to share up-to-date statistics and local, state and national information with agencies and individuals who are active in the field of HIV/STD in Montana. Address corrections and other correspondence should be addressed to editor Helen McCaffrey, HIV/STD Program, MDHES, Cogswell Building, Helena, MT 59620, or telephoned to (406)444-1604. This publication is made possible through funding from the Centers for Disease Control and Prevention.

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Harm Reduction - A New Approach to High Risk Behaviors

The first Harm Reduction conference held in the United States was co-sponsored by the San Francisco-based Harm Reduction Coalition and the University of Washington in Seattle, Washington on January 13, 1995. Terry Peterson, the Montana Department of Health (MDHES) STD/HIV Field Health Officer, attended the conference and was joined by other health care professionals including substance abuse counselors, mental health professionals, and AIDS/HIV street outreach workers from across the nation.

The harm reduction model describes high risk behaviors as ranging along a continuum from excess to abstinence. The risk of harm increases as high risk behaviors become more excessive. Harm reduction encourages and rewards the individual to take small steps to reduce, even to a small degree, the harm caused by a behavior (for example, from the use of drugs or un-safe sexual practices). If a person were injecting IV drugs, harm reduction would consider it an advance if the addict stopped sharing needles or participated in a needle exchange program. A further advance in harm reduction would be if he or she moved to oral drugs or started using condoms and practicing safer sex. Total victory, although not required in harm reduction, would be if the addict stopped using drugs completely.

The harm reduction model is described as a more realistic approach to behavior modification than the "just say no" or an abstinence based approach. Alan Marlatt, a behavioral psychologist from the University of Washington, spent two years in the Netherlands observing their harm reduction model and describes abstinence focused programs as potentially effective for "...individuals who are virgins, or who have never used drugs. But for those individuals that have experienced sex, or are using drugs, just say no just doesn't work. Abstinence from both sex and injecting drugs is the only 100% way not to acquire HIV infection, but abstinence is just not a reality for some individuals."

Programs based on the harm reduction theory allows patients to relapse, and predominately uses group therapy with positive reinforcement. The patient is not punished or criticized for relapsing, but is encouraged to determine why he or she relapsed, and then coached how not to relapse again. The patient is asked to change in small steps instead of one great big one. Imani Woods, a New York City substance abuse counselor, used the comparison of the patient who does not start out on heroin, but who instead works up to it in small steps, similar to climbing up a ladder. The substance abuse counselor would say to the patient "you climbed up this ladder, but we will not say you must jump all the way to the ground. What is needed is goal setting for smaller, more realistic and attainable goals, so the patient can climb down the ladder, and not jump to what they see as their death." Similarly, for high risk behaviors related to HIV and other sexually transmitted diseases, clients would be counseled to decrease behaviors in small steps.

The philosophy of harm reduction would also change the approach of traditional substance abuse programs where individuals have historically have to be abstinent for 60 to 90 days in order to qualify for treatment programs. According to Woods, "Most people can't stay clean long enough to qualify for treatment using this traditional philosophy".

MDHES 1994 Chlamydia Survey

During October 1994, the Montana Department of Health and Environmental Sciences (MDHES) STD Program surveyed 507 Montana Family Practice and OB/GYN physicians about their chlamydia screening and partner management. Chlamydia is the most prevalent STD in Montana. Of the 219 physicians (43%) who returned the survey, 210 were currently practicing medicine.

While the majority of respondents (94%) reported testing patients for chlamydia, 78% screened less than a fourth of their patients of reproductive age. The most common screening criteria reported included patient symptoms, clinical signs, and reported exposure to chlamydia. Because a large proportion of chlamydia infections are asymptomatic, health care providers should be encouraged to expand screening criteria to include factors such as a new partner in the past 90 days, age of patient, and the use of a non-barrier contraceptive. These screening criteria were used by the respondents less than a third of the time.

Forty one percent of respondents estimated that up to one half of their patients are treated presumptively (prescribing medication to treat chlamydia without lab testing) for chlamydia; 20% estimated that over half of their patients are prescribed medication for chlamydia without a lab test. Current Centers for Disease Control and the MDHES recommendations point out that widespread availability of accurate and economical chlamydia tests allows for screening of asymptomatic clients and that chlamydia treatment for symptomatic patients without testing should be discouraged. Some providers do not have the resources to screen asymptomatic patents for chlamydia and to also test patients whose conditions warrant presumptive treatment and partner referral. If presumptive treatment of patients with symptoms or signs of chlamydia without testing is elected, efforts must be made to ensure the treatment of partners.

Respondents reported that notification of sexual partners was carried out most often by the patient notifying the partner to seek medical attention or delivering a prescription to the partner (methods chosen by 83% of the respondents). While notification carried out by the patient may be time- or cost-efficient, it can result in the partner never being notified or referred for treatment. Further, partners may not complete the treatment regimen or be motivated to reduce high risk behaviors. Sexually transmitted disease education and training that includes methods of partner notification and treatment should be accessible to family practice and OB/GYN physicians to assure treatment of partners.

AIDS/STD Program Staff

The AIDS/STD Program welcomes Dick Quist as the new AIDS/HIV Surveillance Officer. Dick earned his Ph.D. in microbiology at Washington State University, Pullman and previously taught at the University of Saskatchewan in Saskatoon. In addition, we welcome Karyn Goodale as the new public health educator with the AIDS Program. She earned her Masters in Public Health from the University of Northern Colorado and has worked in drug prevention and education. She begins her duties in February.

AIDS/STD Courses

During April, the AIDS/STD Program will be providing the STD Interviewing Course which provides training in interviewing for sexually transmitted diseases including HIV. It is designed as an update or introductory course for health care providers who are new to the field. The HIV pre- and post-test counseling course will also be scheduled throughout the spring. Call 444-3565 for details.

Montana Department of Health and Environmental Sciences

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Public Health Educator:	Karyn Goodale
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Administrative Aide:	Kathy Opie

HIV/STD in Montana
Acquired Immunodeficiency Syndrome (AIDS)
Cumulative Surveillance Report - As of December 31, 1994

1. Exposure Category	Adult/Adolescent Males	(%)	Females	(%)	Total	(%)
Men Who Have Sex With Men	144	(66)	0	(0)	144	(60)
Injecting Drug Use	26	(12)	2	(9)	28	(12)
Men Who Have Sex with Men and Injecting Drug Use	27	(12)	0	(0)	27	(11)
Hemophiliac	7	(3)	0	(0)	7	(3)
Heterosexual Contact	6	(3)	14	(61)	20	(8)
Transfusion w/ Blood/Products	3	(1)	4	(17)	7	(3)
None of the Above/Other	6	(3)	3	(13)	9	(4)
Total Adults/Adolescent	219	(100)	23	(100)	242	(100)
	Pediatric					
	Males	(%)	Females	(%)	Total	(%)
Parent at risk/has AIDS/HIV	2	(100)	1	(100)	3	100)
Total Pediatric	2	(100)	1	(100)	3	(100)

2. Age	Cases	(%)
Under 5	3	(1)
5-12	0	(0)
13-19	2	(1)
20-29	58	(24)
30-39	110	(45)
40-49	46	(19)
Over 49	25	(10)
Unknown	1	(0)
Total	245	(100)

3. Race/Ethnicity	Cases	(%)
White, Not Hispanic	215	(88)
Black, Not Hispanic	6	(2)
Hispanic	8	(3)
Asian/Pacific Is.	0	(0)
Am. Indian/Alaskan	16	(7)
Unknown	0	(0)
Total	245	(100)

As of December 31, 1994, there have been 463 cumulative positive HIV tests from 67,090 tests conducted through the MDHES Public Health Laboratory since 1985. Due to anonymous HIV testing, the cumulative number of HIV positive tests may contain duplicates. Nationally, as of June 30, 1994, 401,749 cases of AIDS and 243,423 deaths have been reported to the Centers for Disease Control. *Includes 173 Montana AIDS cases and 72 cases reported to Centers for Disease Control diagnosed in other states who moved to Montana.

STD MORBIDITY REPORT

Disease	Male 1/93-12/93	Male 1/94-12/94	Female 1/93-12/93	Female 1/94-12/94	Total 1/93-12/93	Total 1/94-12/94
Chlamydia						
Private	82	80	390	423	472	503
Public	141	110	699	559	840	669
Military	29	32	19	15	48	47
Indian Health Service	32	37	217	177	249	214
Total	284	259	1325	1174	1609	1433
Chlamydia with PID						
Public	0	0	13	19	13	19
Private	0	0	2	10	2	10
Total	0	0	15	29	15	29
Uncomplicated Gonorrhea						
Private	13	17	14	13	27	30
Public/Military	10	18	17	18	27	36
Indian Health Service	8	7	17	14	25	21
Total	31	42	48	45	79	87
Syphilis-Pri/Sec	0	0	1	3	1	3
Syphilis-El						
Private	1	1	0	0	1	1
Public	2	3	0	1	2	4
Syphilis-Nuero	0	0	0	1	0	1
Total	3	4	1	5	4	9

To report cases of patients who meet the CDC definition of AIDS, please contact Dick Quist, Surveillance Officer, at HIV/STD Program, (406)444-4744.

HIV Prevention Community Planning - Update

During 1994, the Montana Department of Health & Environmental Sciences (MDHES) and communities state-wide collaborated in a community planning process to develop priorities for the use of federal HIV prevention funds received by the MDHES. The goal of the community planning process is to use a fully open and participatory process to develop a state-wide comprehensive plan that will outline the priorities for the state's HIV/AIDS prevention activities and will support applications for continued and supplemental funding for HIV prevention in Montana.

In Montana, the community planning process has built upon the assessments and prevention recommendations contained in the recent Report to the Governor: Montana Responds to HIV/AIDS (4/94). Five regional planning groups evaluated regional and state epidemiologic profiles and the interventions for HIV prevention already in place, and from those developed HIV prevention priorities. The planning groups included representation from local health departments, community-based service organizations, schools, the prison system, populations affected by the epidemic, youth advocates, health care providers, tribal health departments, family planning and others.

In October 1994, Montana's application for funding for HIV prevention was found not to be in compliance with some of the federal planning guidance. Participants at state-wide meetings held in October, December and January reviewed regional planning group progress and developed priorities and interventions for the state-wide comprehensive plan for HIV prevention in Montana. In December, the state-wide planning group, *Montanans Planning for HIV Prevention*, was created. The state-wide group is composed of two representatives of each regional planning groups and MDHES. Members include Tina Stauffacher and Jeanne Seifert of Glendive, Mark Kittock and Terry Priete of Great Falls, Ron Seibel and Jean Omelchuck of Billings, Dan Dennehy of Butte and David Gay of Bozeman, Timothy Farwood of Kalispell and Aylett Wright of Missoula, and Bruce Desonia and Claudia Montagne of Helena.

Claudia Montagne, health educator for MDHES, has been assigned to coordinate the community planning process for the Department beginning in December. On February 10, the state-wide planning groups will have a video teleconference to review the main and supplemental applications for federal funding. Those interested in the HIV prevention planning process may contact their regional planning group or Claudia at 444-3565. In addition, at least one of the co-chairs from each region will be attending a national conference in March to assess the progress of community planning and to discuss new approaches and strategies for HIV prevention.

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